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Strengthening the Medicare Program: Meeting the Needs of an Aging Population

{On March 4, President Bush issued a framework for Medicare reform as a guide for Congress. The framework is based on the premise that all seniors should have the option of a prescription drug benefit as part of Medicare. This paper, which examines prescription drugs and the need for disease management, is the first in a series as Congress works to improve the Medicare program for its beneficiaries.}

Introduction

In general, chronic medical conditions increase with age. These conditions include, but are not limited to, congestive heart failure, hypertension, eye disorders, renal disease, diabetes, arthritis, and asthma. Nearly three-fourths of today's Medicare beneficiaries have at least one chronic condition; almost two-thirds have two or more chronic illnesses.[1] According to the Tufts Center for the Study of Drug Development, "the Medicare program accounts for nearly 17 percent of total U.S. health care spending and nearly 60 percent of total U.S. spending on chronic care."[2] Yet as the Baby Boom generation retires, the Medicare program is severely unprepared to meet the pressures of this growing elderly population.

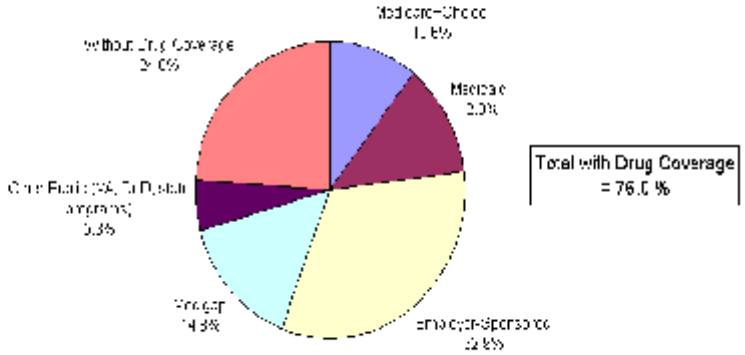
The nation's health care system has undergone a major transformation in the marketplace with the explosion of new drug therapies for chronic medical conditions.[3] Prescription drug spending for the nation is growing faster than any other segment of the health care system, leading to a change in the way patients receive health care services. However, the Medicare program does not include coverage for most outpatient prescription drugs, prohibiting it from addressing many new and improved medical treatments. Current data suggest that integrating prescription drug coverage and disease management, among other reforms, into the Medicare program can be key to improving the quality of life for our seniors and simultaneously achieving cost efficiencies over the long-term.

Is Today's Medicare Program Outdated for Today's Beneficiaries?

The Medicare program covers nearly 40 million beneficiaries who are aged 65 and older and/or disabled. It was created in 1965 to provide federal health insurance for some hospital, skilled nursing, physician, hospice, and home health services. The program sets strict limits on pharmaceuticals. Coverage is restricted only to those drugs administered to inpatients of hospitals or skilled nursing facilities, or those drugs that must be injected by a physician.

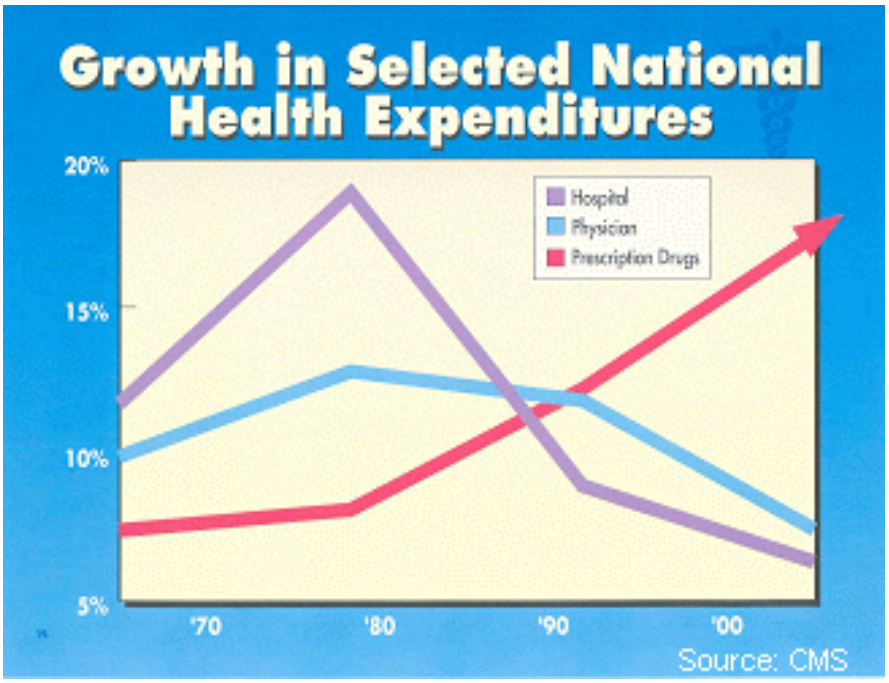
Medicare's rules and regulations force seniors to look outside the program in search of prescription drug coverage. Approximately a quarter (24 percent) of today's beneficiaries lack such coverage and must pay for their medicines out-of-pocket. For those with coverage, the various policies are often fragmented and expensive. Supplemental coverage is obtained through either employer retiree plans (33 percent), Medigap policies (15 percent), Medicare + Choice (11 percent), Medicaid (12 percent), or other public programs such as the Veterans Administration, Department of Defense, and state pharmacy programs (5 percent) (see chart below).[4] Despite the presence of supplemental coverage, Medicare beneficiaries still pay an average of one-third of their drug expenses out-of-pocket.[5] According to the Congressional Research Service, in 1998, those beneficiaries with coverage paid an average of $380 for prescription drugs; and for those without coverage, beneficiaries paid approximately $545 out-of-pocket.[6] These expenditures are in addition to Medicare expenses for monthly premiums, deductibles, and coinsurance.

Percent of Medicare Beneficiaries with Drug Coverage, by Source of Coverage (2002 Projection)



SOURCE: Projection of Medicare beneficiaries by Actuarial Research Corporation, July 2002

The emergence of prescription drugs has led to a shift in practice patterns (see chart below).[7] This shift has helped health care providers better target diseases, and ultimately prevent repeat hospital admissions. For example, new drugs called "statins" can reduce heart attacks in older persons. This further reduces the risk of stroke and costly hospitalization stays. Other new drugs that promote calcium absorption into the bones have been shown to reduce serious complications of osteoporosis, including fractures, in older women.[8] Bone fractures are a major cause of long and costly hospitalizations, including nursing home admissions and, in some cases, death. Due to its antiquated structure, the Medicare program is unable to benefit from these types of advanced treatments. As a result, the program is ill-prepared to meet the growing needs of the aged.



Integrating Disease Management and Drug Therapy: Tools to Creating a More Cost-Efficient Medicare Program

As Congress works to improve the Medicare program, it is important to keep the following demographic pressures in mind:

- Enrollment is expected to reach 77 million by 2031;[9]
- The number of Americans over age 65 is rapidly increasing; and[10]
- The prevalence of chronic conditions increases with age.[11]

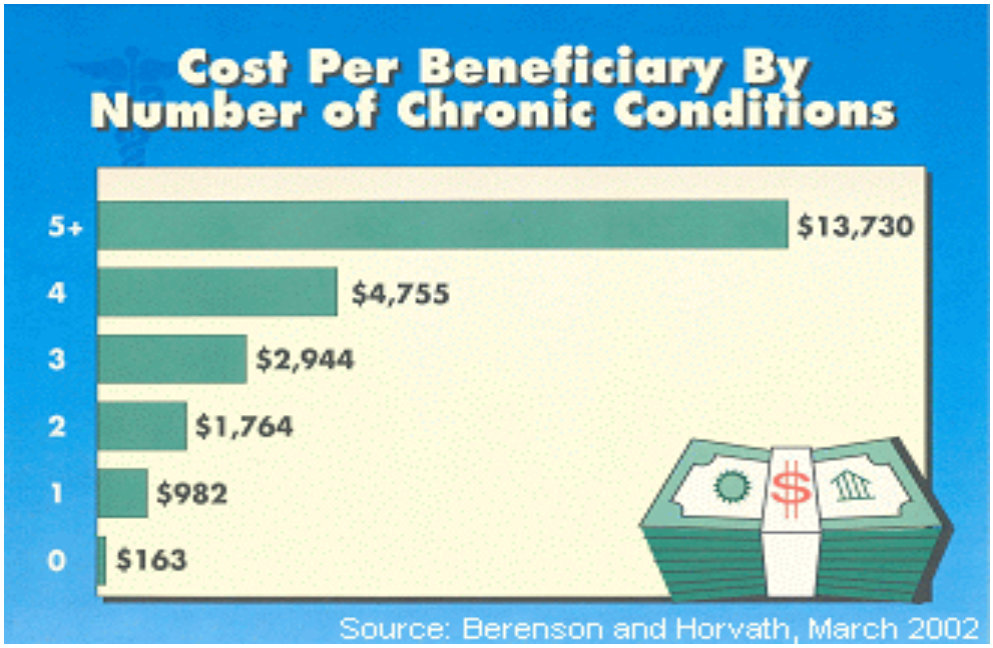
According to the Administration on Aging, "the number of persons between 65 and 74 was eight times larger in 2000 than in 1900, the number of persons between 75 and 84 was 16 times larger, and the

number of seniors over age 85 was 34 times larger."[12]

During a recent hearing before the U.S. Senate Special Committee on Aging, the Office of Personnel Management and others testified that current Medicare benefits are inferior to those offered by the Federal Employees Health Benefit Program (FEHBP). The FEHBP contracts with private health plans that specifically offer preventative care, pharmaceutical benefits and disease management. While not all of the witnesses agreed on the exact recipe for Medicare reform, they each concluded that the Medicare program must do a better job fostering these types of treatment innovations for its beneficiaries.[13]

According to the Congressional Budget Office, the Medicare program is limited in its ability to treat patients suffering from multiple medical conditions. Such patients often "receive care from many different physicians or providers at the same time, take a number of different drugs to treat the various conditions, and are called on to manage their own care at home. [As a result], the responsibility for coordinating care among physicians and other providers falls on the patient, who may have a limited ability to carry out that function."[14]

Effective disease management and drug therapy can help alleviate that burden for high-risk, high-cost patients with complex medical problems. Together, they provide a comprehensive approach, utilizing evidence-based medicine, patient education, and regular health status evaluations. Case managers intervene on behalf of the patient for the purpose of coordinating care among an array of providers, recommending preventative care, and monitoring any adverse medical reactions. In essence, the goal is to move away from treating patients in an acute, episodic manner to one that regularly evaluates patients to help slow disease progression and maintain the functional status of the individual. Because the Medicare program serves a disproportionate share of individuals with chronic conditions, these techniques can have real implications for overall, annual program costs (see chart below).[15]



According to the Tufts Center for the Study of Drug Development, there is growing evidence that the increased use of pharmaceuticals, combined with disease management programs, may help control growing Medicare costs since many beneficiaries suffer from multiple chronic diseases.[16] Private health plans have long known about the benefits of chronic care management by implementing patient education programs, nutrition counseling, routine evaluations, and prescription medicines. The American Association of Health Plans 2001 Industry Survey reports that 97 percent of health plans have disease management programs for diabetes, 86 percent for asthma, and 83 percent for congestive heart failure.[17]

One example of the efficiencies that may be achieved is a study which monitored health plan enrollees (average age 60) diagnosed with adult-onset diabetes. The study tried to determine whether drug therapy and disease management could reduce utilization of health care services and achieve significant cost savings. Adult-onset diabetes, also referred to as Type 2 diabetes, is the sixth leading cause of death in the United States and often leads to blindness, kidney failure, amputation, heart disease and stroke. The study suggested "health care savings of approximately $685 to $950 per patient upon improved glucose control."[18]

Although most disease management experience occurs among large employers and health plans, there can be replications in traditional health care settings. The Botsford Community Hospital, a 330-staffed bed facility in Farmington Hills, Michigan, recently implemented a disease management and drug therapy program for its congestive heart failure patients. Preliminary results from the study indicated lower lengths of stay and approximately $2,400 in savings per patient while maintaining patient and nursing staff satisfaction.[19] Congestive heart failure is the leading cause of hospitalization among older adults and the most costly cardiovascular disorder in the Medicare population.

The Centers of Medicare and Medicaid Services, the federal agency responsible for administering Medicare and Medicaid services and payments, also is studying a series of demonstration projects located in rural and urban areas. The projects currently are testing whether disease management and drug therapy can be integrated to improve health status, reduce avoidable hospital admissions, and promote other desirable outcomes among Medicare beneficiaries with chronic diseases.[20]

Historic Opportunity

Applying the lessons learned from private health plans, disease management organizations, and academic medical centers will help pave the way for a stronger Medicare program as its beneficiaries grow in numbers and age. Congress has an historic opportunity to improve the program. It has an opportunity to reshape Medicare from a fragmented model where beneficiaries receive health care services from multiple providers and multiple sites of care, to a more integrated program that emphasizes a full patient treatment plan. In short, a model that keeps pace with medical advancements for today's and tomorrow's beneficiaries.

On April 11, Congress took the first step toward this goal by reserving $400 billion over 10 years for improvements discussed in this paper.[21] Earlier this year, President Bush also announced his commitment to improve the Medicare program by issuing a detailed framework based on the following principles:[22]

- All seniors should have the option of a prescription drug benefit as part of Medicare;
- Medicare should provide better coverage for preventative care and serious illnesses;
- Beneficiaries should have the option of keeping the traditional plan with no changes;
- Medicare should provide better health insurance options, like those available to federal employees;
- Medicare legislation should strengthen the program's long-term financial security.
- The management of the Medicare plan should be strengthened so that it can provide better care for seniors;
- Medicare's regulations and administrative procedures should be updated and streamlined, while the instances of fraud and abuse should be reduced; and
- Medicare should encourage high-quality care for seniors.

Passing legislation based on these guidelines will help foster medical innovation for our nation's frail elderly and disabled persons. As the Medicare population grows, it is critical that the program adapt to new forms of patient care, which includes prescription drug coverage and disease management. Together, these tools will improve the quality of life for Medicare's current and future beneficiaries, as well as lead to cost efficiencies in the long run.

Written by Health Care Policy Analyst Diane Major, 224-2946

Endnotes

1.Robert A. Berenson, M.D., and Jane Horvath, "The Clinical Characteristics of Medicare Beneficiaries and Implications for Medicare Reform," Partnership for Solutions, March 2002.

2.Tufts Center for the Study of Drug Development, "Disease Management Cuts Inpatient Costs Via Greater Drug Spending," *Impact Report*, Volume 4, Number 2, March/April 2002.

3.The emergence of biologicals and medical devices also have altered our nation's health care landscape significantly. However, this paper will focus solely on pharmaceuticals and disease management therapies for the aged suffering from chronic medical conditions.

4. Centers for Medicare and Medicaid Services, "Percent of Medicare Beneficiaries with Drug Coverage, by Source of Coverage (2002 projection)."

5. John A. Poisal, Lauren A. Murray, George S. Chulis, and Barbara S. Cooper, "Prescription Drug Coverage and Spending for Medicare Beneficiaries," *Health Care Financing Review*, Volume 20, Number 3, Spring 1999.

6. Jennifer O'Sullivan, "Medicare Prescription Drug Coverage for Beneficiaries: Background and Issues," Congressional Research Service, January 6, 2003.

7. Tom Scully, "Health Care Industry Market Update: Pharmaceuticals," Centers for Medicare and Medicaid Services, January 10, 2003.

8. White House, "Improving Medicare Benefits," July 2001.

9. National Bipartisan Commission on the Future of Medicare, "The Facts about Medicare."

10. Administration on Aging, "Profile of Older Americans: 2002," December 2002.

11. Berenson and Horvath, 5.

12. Administration on Aging, 1.

13. United States Special Committee on Aging, "Medicare Reform and Competition: Separating Fact From Fiction," Hearing, May 6, 2003.

14. Dan L. Crippen, "Disease Management in Medicare: Data Analysis and Benefit Design Issues," Congressional Budget Office testimony before the Special Committee on Aging, United States Senate, September 19, 2002.

15. Berenson and Horvath 6.

16. Tufts 1.

17. American Association of Health Plans, "Highlights of 2001 AAHP Annual Industry Survey," Disease Management and Chronic Care, August 2002.

18. Edward H. Wagner, M.D., MPH; Nirmala Sandhu, MPH, Katherine M. Newton, PhD; David K. McCulloch, M.D.; Scott D. Ramsey, M.D., PhD; Louis C. Grothaus, MS, "Effect of Improved Glycemic Control on Health Care Costs and Utilization," *Journal of the American Medical Association (JAMA)*, Vol. 285, No. 2, January 10, 2001.

19. Cheryl L. Discher, RN, BSN; Dahlia Klein, RN, MSN, CCM; Lisa Pierce, RN, MSN, CNP; Arlene B. Levine, MD; and T. Barry Levine, MD, "Heart Failure Disease Management: Impact on Hospital Care, Length of Stay, and Reimbursement," *Congestive Heart Failure*, April 16, 2003 (www.medscape.com).

20. Stuart Guterman, "Eliminating Barriers to Chronic Care Management in Medicare," Centers for Medicare and Medicaid Services testimony before the House Ways and Means Subcommittee on Health, February 25, 2003.

21. H. Con. Res 95, The Concurrent Budget Resolution for FY 2004.

22. The White House, "21st Century Medicare More Choices, Better Benefits: A Framework to Modernize and Improve Medicare," March 2003.